Division of Human Resources

HealthLine

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Changes & Improvements for FY11

Change is the key for this year's open enrollment for benefits. With these changes come a number of improvements. Because of these changes and improvements, this is not only a mandatory open enrollment, but an important one too. Please read the information contained in this issue of *HealthLine* to help decide on the best benefit choices for you and your family.

Medical Changes & Improvements

- United Healthcare (UHC) takes over from Great-West/CIGNA as the administrator for the self-funded plan.
- Two "Choice Plus" options replace the OA options—Choice Plus and Choice Plus Definity, which is a Health Savings Account (HSA)-qualified option.
- You asked, we listened—Over the last few years, Employee Benefits heard from many employees in the self-funded plan, asking for co-pays to be a part of plan. The Choice Plus option has co-pays for office visits, preventive care and inpatient hospital stays. Co-pays are convenient in helping you predict the cost of care.
- Both the Choice Plus and the Choice Plus Definity options have been designed to be simple to understand and simple to use. Co-pays, a large and robust network of doctors and hospitals, simple plan designs and a wealth of resources will help employees to understand their choices and costs, while making it easier to access appropriate care.
- Kaiser will now offer an HSA-qualified option in addition to the Kaiser HMO. This option, called the Kaiser High-Deductible Health Plan (HDHP) will NOT use co-pays, but instead have a deductible that must be met before services will be covered. HSAs allow savings for future medical expenses.
- San Luis Valley HMO will not be offered for FY11 and will not be a choice in this open enrollment.

Dental Changes & Improvements

- Increases in the annual and lifetime maximum benefits in the Basic Plus plan—from $1500 to $2000.
- Composite (white) fillings for back teeth will be now be covered under basic services in both the Basic and Basic Plus plans.
- The Direct Reimbursement (DR) dental plan will not be offered in FY11 and will not be a choice in this open enrollment.

Special Note to CU State Classified Staff

State personnel system employees with the University of Colorado **MUST** use CU's online system for open enrollment.

Other Changes & Improvements

- Employees will be able to choose coverage for their same-gender domestic partners (SGDPs) as part of this open enrollment, with coverage to be effective July 1, 2010.

FY11 Open Enrollment—Logistics and Facts

- Open Enrollment is **May 4–May 20, 2010.** Participation is **MANDATORY**, as current medical and dental coverage **WILL NOT** roll forward into the next plan year. If you do not make a choice for medical and dental coverage during open enrollment, you and your family will not have medical and dental coverage for FY11, which starts July 1, 2010.
- Enrollment is for the FY11 Plan Year—July 1, 2010 to June 30, 2011.
- Open Enrollment is completed ONLY through the State's online Benefits Administration System (BAS), accessed at **www.colorado.gov/dpa/dhr/benefits**, where you can also research your benefit options, view premiums, review online system instructions.
- Flexible Spending Accounts (FSAs) do not roll over to the next plan year, and must be chosen every year. **Those who want an FSA in FY11 must enroll in the FSA during Open Enrollment.**
- Open Enrollment is the ONLY TIME to make changes to your benefits, except in very limited, life altering circumstances. Forgetting to enroll, not confirming online choices, suffering a financial hardship, or just a change of mind are not permitted reasons for making changes beyond Open Enrollment (per IRS regulations).
- Social security numbers for spouses, same-gender domestic partners and dependent children are required when enrolling.
- Complete your enrollment early to avoid last-minute problems.
- Use Open Enrollment to update dependent information and remove any ineligible dependents (e.g., overage children, ex-spouses).
- If you are terminating your employment with the State *before* July 1, 2010, DO NOT PARTICIPATE in the FY11 Open Enrollment. Contact the State's COBRA administrator at 1.877.725.4545 for information about COBRA continuation coverage.

FY11 Medical and Dental Premiums

FY11 MEDICAL OPTIONS					
OPTION	**TIER**	**Total Premium**	**State Contribution**	**Additional Funding***	**Employee Contribution**
Choice Plus Definity HSA-qualified option	Employee Only	$376.98	$356.92	$13.06	$7.00
	Employee + Spouse	$823.54	$602.82	$22.04	$198.68
	Employee + Child(ren)	$674.68	$637.96	$23.32	$13.40
	Ee + Sp + Child(ren)	$1,121.26	$883.84	$32.32	$205.10
Choice Plus	Employee Only	$439.10	$356.92	$13.06	$69.12
	Employee + Spouse	$960.08	$602.82	$22.04	$335.22
	Employee + Child(ren)	$786.42	$637.96	$23.32	$125.14
	Ee + Sp + Child(ren)	$1,307.44	$883.84	$32.32	$391.28
Kaiser HDHP HSA-qualified option (Denver/Boulder & Southern Colorado)	Employee Only	$379.36	$356.92	$13.06	$9.38
	Employee + Spouse	$828.36	$602.82	$22.04	$203.50
	Employee + Child(ren)	$678.36	$637.96	$23.32	$17.08
	Ee + Sp + Child(ren)	$1,127.36	$883.84	$32.32	$211.20
Kaiser HMO (Denver/Boulder & Southern Colorado)	Employee Only	$454.36	$356.92	$13.06	$84.38
	Employee + Spouse	$993.36	$602.82	$22.04	$368.50
	Employee + Child(ren)	$813.36	$637.96	$23.32	$152.08
	Ee + Sp + Child(ren)	$1,352.36	$883.84	$32.32	$436.20

FY11 DENTAL OPTIONS				
OPTION	**TIER**	**Total Premium**	**State Contribution**	**Employee Contribution**
Dental Basic	Employee Only	$22.96	$19.78	$3.18
	Employee + Spouse	$50.32	$32.16	$18.16
	Employee + Child(ren)	$41.20	$33.92	$7.28
	Ee + Sp + Child(ren)	$68.54	$46.32	$22.22
Dental Basic Plus	Employee Only	$34.30	$19.78	$14.52
	Employee + Spouse	$75.18	$32.16	$43.02
	Employee + Child(ren)	$61.54	$33.92	$27.62
	Ee + Sp + Child(ren)	$102.40	$46.32	$56.08

* The Joint Budget Committee (JBC) of the Legislature authorized the application of additional funds toward the cost of medical coverage for state employees, both through additional state contributions and through application of a financial relief payment sent to the State as a Kaiser policy holder. These actions resulted in a decrease to the employee's contribution for medical for FY11.

This premium information reflects the State funding level as currently reflected in the Long Bill, which is in the final stages of the legislative process. Should these employer contribution amounts change, the State and employee contributions will be adjusted accordingly amongst the four coverage levels. If adjusted contributions become necessary, a revised chart will be made available on our Web site ***www.colorado.gov/dpa/dhr/benefits*** *and sent to your department's benefits, payroll, and HR staff. Watch for communication from us or from your department for any updates. However, do not delay your open enrollment until the last minute.*

Division of Human Resources

FY11 Benefits Information

Current FY10 medical and dental benefits WILL NOT roll over into FY11 (July 1, 2010–June 30, 2011). Participation in open enrollment is mandatory. If you do not make new medical and dental choices for you and your family, you will not have medical and dental coverage on July 1, 2010.

Review this information to help you decide what's best for you and your family for the FY11 plan year. Visit **www.colorado.gov/dpa/dhr/benefits** to find out more about the FY11 benefits.

Medical Insurance

Significant changes in choices for medical insurance are the biggest difference for this open enrollment. United Healthcare replaces Great-West/CIGNA, Kaiser will offer a second option for their plan, and San Luis Valley HMO will ***not*** be offered. Employees MUST make a new choice for state medical insurance during open enrollment, as current choices will not roll forward to FY11 (starting July 1, 2010).

Note: San Luis Valley HMO will NOT be offered for FY11, and will not be a choice during this open enrollment.

Self-Funded Plan (to be administered by United Healthcare)

www.welcometouhc.com/colorado (a pre-member site)/ 1.877.283.5424

United Healthcare (UHC) will replace Great-West/CIGNA as the administrator for the state's self-funded medical plan. This means that the OA options go away, to be replaced by two options called Choice Plus and Choice Plus Definity.

Choice Plus

Key highlights: In-network physician and specialist office visits have a co-payment. Services without co-payments will require that the member pay for the cost until the deductible has been met.

Choice Plus In-Network benefit highlights

- Individual deductible—$1500; Family deductible—$3000
- Out-of-pocket individual maximum—$5000; Family out-of-pocket maximum—$10,000
- Office visit, primary physician—$30 co-pay whether or not the deductible has been met
- Office visit, specialist—$50 co-pay whether or not the deductible has been met
- Inpatient hospital—$1000 co-pay, remaining balance paid at 80%—whether or not the deductible has been met

Healthcare Terminology—Knowing these terms will help you to understand your choices.

Co-Pay—A flat fee that is paid for health care services at the time service is provided. Co-payments are specific amounts, which is convenient in planning for the cost of care.

Deductible—An amount an individual must pay for covered health care expenses before insurance begins to cover costs. Deductibles in health insurance work the same as deductibles in auto or home owner's insurance.

Co-insurance—A percentage of costs for covered services that the insurance company pays *after* a deductible is met.

Out-of-Pocket Maximum—The maximum amount of money a person will pay for covered health claims, which is in addition to premium payments. These maximums are usually the sum of deductibles and co-insurance payments or the sum of all co-payments.

- Preventive Care Services—Co-pays apply regardless of whether deductible has been met
  - Office visit, primary physician—$10 co-pay
  - Office visit, specialist—$10 co-pay
  - Lab, X-Ray, Scopic (exam only), mammograms, and PSA tests—no charge (100% covered whether or not the deductible has been met)
- Co-insurance once deductible has been met—80% (for services without a co-pay or where the deductible does not apply); this means that for services without co-pays, once the deductible has been met, the member will pay 20% of the cost.
- Pharmacy
  - No pharmacy deductible
  - Three tiers—see **www.colorado.gov/dpa/dhr/benefits** to see the drug list.
    - Tier 1—$10 co-pay
    - Tier 2—$25 co-pay
    - Tier 3—$50 co-pay
  - Mail Order—2½ co-pays for up to 90-day supply

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Choice Plus Out-of-Network benefit highlights

- Individual deductible—$3000; Family deductible—$6000
- Out-of-pocket individual maximum—$10,000; Family out-of-pocket maximum—$20,000
- Office visit, primary physician—no co-pay, visit paid at 50% *after* deductible has been met, otherwise member pays for visit
- Office visit, specialist—no co-pay, visit paid at 50% *after* deductible has been met, otherwise member pays for visit
- Inpatient hospital—no co-pay, visit paid at 50% *after* deductible has been met, otherwise member pays for visit
- Preventive Care Services
  - Office visit, primary physician—no co-pay, visit paid at 50% *after* deductible has been met, otherwise member pays for visit
  - Office visit, specialist—no co-pay, visit paid at 50% *after* deductible has been met, otherwise member pays for visit
  - Lab, X-Ray, Scopic, other preventive tests—no co-pay, visit paid at 50% *after* deductible has been met, otherwise member pays for test
- Pharmacy (same as in-network pharmacy benefits)
  - No pharmacy deductible
  - Three tiers—see **www.colorado.gov/dpa/dhr/benefits** to see the drug list.
    - Tier 1—$10 co-pay
    - Tier 2—$25 co-pay
    - Tier 3—$50 co-pay
  - Mail Order—2½ co-pays for up to 90-day supply

Choice Plus Definity

The Choice Plus Definity option is a Health Savings Account (HSA)-qualified option. This option will NOT have co-pays like the Choice Plus option, but will instead use deductibles and co-insurance amounts. **Except for preventive services, the entire deductible must be met before this option pays a co-insurance amount.** HSAs can only be used with an HSA-qualified plan, also called a high-deductible health plan or HDHP.

Choice Plus Definity In-Network benefit highlights

- Individual Deductible—$1500 (the individual deductible is ONLY for the Employee-Only tier level)
- Family Deductible—$3000 (family deductible is for all tiers EXCEPT Employee-Only)
- Individual Out-of-Pocket Maximum—$3000 (the individual out-of-pocket maximum is ONLY for the Employee-Only tier level)
- Family Out-of-Pocket Maximum—$6000 (family out-of-pocket maximum is for all tiers EXCEPT Employee-Only)
- Office visit, primary physician—no co-pay, visit paid at 80% *after* deductible has been met, otherwise member pays for visit
- Office visit, specialist—no co-pay, visit paid at 80% *after* deductible has been met, otherwise member pays for visit
- Inpatient hospital—no co-pay, visit paid at 80% *after* deductible has been met, otherwise member pays for visit
- Preventive Care Services—Co-pays and coverage are regardless of whether deductible has been met
  - Office visit, primary physician—$30 co-pay
  - Office visit, specialist—$30 co-pay
  - Lab, X-Ray, Scopic, other preventive tests—no charge (100% covered regardless of deductible)
- Pharmacy
  - Three tiers—see **www.colorado.gov/dpa/dhr/benefits** to see the drug list.
  - Member pays the full cost of prescription medications until the medical deductible has been met. After that, prescriptions will fall under the co-pay amounts listed below.
    - Tier 1—$10 co-pay—However, co-pays do not apply until medical deductible amount has been met.
    - Tier 2—$25 co-pay—However, co-pays do not apply until medical deductible amount has been met.
    - Tier 3—$50 co-pay—However, co-pays do not apply until medical deductible amount has been met.
  - Mail Order—2½ co-pays for up to 90-day supply, after medical deductible has been met

Choice Plus Definity Out-of-Network benefit highlights

- Individual Deductible—$4500 (the individual deductible is ONLY for the Employee-Only tier level)
- Family Deductible—$9000 (family deductible is for all tiers EXCEPT Employee-Only)
- Individual Out-of-Pocket Maximum—$9000 (the individual out-of-pocket maximum is ONLY for the Employee-Only tier level)
- Family Out-of-Pocket Maximum—$18,000 (family out-of-pocket maximum is for all tiers EXCEPT Employee-Only)
- Office visit, primary physician—no co-pay, visit paid at 50% *after* deductible has been met, otherwise member pays for visit
- Office visit, specialist—no co-pay, visit paid at 50% *after* deductible has been met, otherwise member pays for visit
- Inpatient hospital—no co-pay, visit paid at 50% *after* deductible has been met, otherwise member pays for visit

- Preventive Care Services—
  - Office visit, primary physician—no co-pay, visit paid at 50% *after* deductible has been met, otherwise member pays for visit
  - Office visit, specialist—no co-pay, visit paid at 50% *after* deductible has been met, otherwise member pays for visit
  - Lab, X-Ray, Scopic, other preventive tests—no co-pay, visit paid at 50% *after* deductible has been met, otherwise member pays for test
- Pharmacy
  - Three tiers—see **www.colorado.gov/dpa/dhr/benefits** to see the drug list.
  - Member pays the full cost of prescription medications until the medical deductible has been met. After that, prescriptions will fall under the co-pay amounts listed below.
  - If a member uses an out-of-network pharmacy, then the out-of-network deductible must be met before the co-pay amounts apply.
    - Tier 1—$10 co-pay—However, co-pays do not apply until medical deductible amount has been met.
    - Tier 2—$25 co-pay—However, co-pays do not apply until medical deductible amount has been met.
    - Tier 3—$50 co-pay—However, co-pays do not apply until medical deductible amount has been met.
  - Mail Order—2½ co-pays for up to 90-day supply, after medical deductible has been met

Kaiser

www.kaiserpermanente.org/303.338.3800/1.800.632.9700

New for FY11, Kaiser will offer two options—the Kaiser HMO option, similar to the option currently available for FY10 and that has been offered for a number of years; and a Health Savings Account (HSA)-qualified option. Both Kaiser options will be available to employees living in Denver, Boulder and parts of Southern Colorado, as based upon employees' home zip codes. Find the Kaiser service area zip codes at **www.colorado.gov/dpa/dhr/benefits**.

Kaiser HMO Highlights

- Office visit, primary care physician (PCP)—$30 co-pay
- Office visit, specialist—$50 co-pay
- Preventive care—$15 co-pay (adult or child)
- Inpatient hospital—$750 co-pay per admission
- Laboratory & X-ray
  - Diagnostic lab and diagnostic x-ray—no charge (100% covered)
  - Therapeutic x-ray—$50 co-pay each visit
  - MRI/CT/PET scans—$100 co-pay per procedure
- Pharmacy
  - Generic prescriptions—$10 co-pay
  - Brand name prescriptions—$30
  - Mail-order prescriptions—2 co-pays for a 90-day supply.
  - Specialty prescriptions/injectables—Members pay 20% of cost, up to a maximum of $75 per drug dispensed.

Kaiser High Deductible Health Plan (HDHP) Highlights—an HSA-Qualified Option

Kaiser's high deductible health plan (HDHP) will NOT have co-pays like the Kaiser HMO option, but will instead use deductibles and co-insurance amounts. This is due to the federal regulations on how an HDHP should be designed. **Except for preventive services, the entire deductible must be met before Kaiser pays co-insurance.** This option is a Health Savings Account (HSA)-qualified option. HSAs can only be used with an HSA-qualified plan.

- Individual Deductible—$1200 (ONLY for the Employee-Only tier); Family Deductible—$2400 (all tiers EXCEPT Employee-Only)
- Individual Out-of-Pocket Max—$2500 (Employee-Only tier); Family Out-of-Pocket Max—$5000 (all other tiers)
- Office visit, primary care physician (PCP)—90% co-insurance, after deductible is met; until deductible is met, member pays the cost
- Office visit, specialist—90% co-insurance, after deductible is met; until deductible is met, member pays the cost
- Inpatient hospital—After deductible has been met, 90% co-insurance
- Preventive care—no charge, 100% covered (adult or child)
- Laboratory & X-ray
  - Diagnostic lab and diagnostic x-ray—90% co-insurance, after deductible is met; until deductible is met, member pays the cost
  - Therapeutic x-ray—90% co-insurance, after deductible is met; until deductible is met, member pays the cost
  - MRI/CT/PET scans—90% co-insurance, after deductible is met; until deductible is met, member pays the cost
- Pharmacy—**Co-pays only apply once deductible has been met**
  - Generic prescriptions—$10 co-pay—However, co-pays do not apply until medical deductible amount has been met.
  - Brand name prescriptions—$40—However, co-pays do not apply until medical deductible amount has been met.
  - Mail-order prescriptions—2 co-pays for a 90-day supply—However, co-pays do not apply until medical deductible amount has been met.
  - Specialty prescriptions/injectables—After deductible is met, members pay 20% co-insurance, up to a maximum of $100 per drug dispensed.

Dental Insurance—Administered by Delta Dental

www.deltadental.com/1.800.489.7168

Improvements to both plans in terms of services covered, as well as an increase in the annual maximum for the Basic Plus plan, are the key items for FY11. Due to low enrollment, the Direct Reimbursement (DR) will *not* be offered for FY11 and will not be a choice during this open enrollment. Employees **MUST** make a new choice for state dental insurance during open enrollment, as current choices will not roll forward to FY11 (starting July 1, 2010).

IMPORTANT NOTE: Coverage in both the Basic and Basic Plus plans is based upon the in-network prices for services. In-network dentists have agreed with Delta Dental to not charge above certain amounts for services. Employees and their families may use out-of-network dentists, but the coverage is based on the in-network pricing, and the employee will be responsible for the difference between the in-network pricing and the charges by the out-of-network dentist.

Basic Plan

- New for FY11, composite (white) fillings for posterior (back) teeth will be covered under Basic services, subject to the annual maximum benefit.
- Also new for FY11, implants will be covered under Major services in the plans, subject to the annual maximum benefit.
- Plan Year Deductibles—individual $50, Family $150
- Annual Maximum Benefit for an individual—$1000
- Preventive and Diagnostic Services (e.g., routine cleanings, oral evaluations, fluoride treatments, full-mouth and bitewing x-rays, sealants)
  - No deductible
  - Paid at 100% of in-network pricing
- Basic Services (e.g., composite (white) fillings, amalgam (silver) fillings, extractions, surgical periodontal (gums), root canal therapy)
  - Deductible must be met before services paid.
  - Paid at 70% of in-network pricing
- Major Services (e.g., crowns, full and partial dentures, bridges, implants)
  - Deductible must be met before services paid.
  - Paid at 50% of in-network pricing
- No orthodontia services in the Basic Plan

Basic Plus Plan

- New for FY11, an increase from $1500 to $2000 for annual maximum benefit.
- Increase from $1500 to $2000 for lifetime maximum for orthodontia—Be advised that this increased benefit will only be for completely NEW orthodontia treatment plans that begin in FY11 (July 1, 2010–June 30, 2011). Any orthodontia treatment plans begun before July 1, 2010, will still be subject to the $1500 lifetime maximum.
- New for FY11, composite (white) fillings for posterior (back) teeth will be covered under Basic services, subject to the annual maximum benefit.
- Also new for FY11, implants will be covered under Major services in the plans, subject to the annual maximum benefit.
- Plan Year Deductibles—individual $50, Family $150
- Annual Maximum Benefit for an individual—increased to $2000
- Preventive and Diagnostic Services (e.g., routine cleanings, oral evaluations, fluoride treatments, full-mouth and bitewing x-rays, sealants)
  - No deductible
  - Paid at 100% of in-network pricing
- Basic Services (e.g., composite (white) fillings, amalgam (silver) fillings, extractions, surgical periodontal (gums), root canal therapy)
  - Deductible must be met before services paid.
  - Paid at 80% of in-network pricing
- Major Services (e.g., crowns, full and partial dentures, bridges, implants)
  - Deductible must be met before services paid.
  - Paid at 50% of in-network pricing
- Orthodontia Services
  - No deductible
  - Paid at 50% of in-network pricing
  - Lifetime maximum orthodontia benefit—increased to $2000

Optional Life Insurance—Provided by Minnesota Life

- There are no changes to optional life insurance or the premiums. Remember, there are separate premiums for employees and spouses. View the voluntary life premiums at **www.colorado.gov/dpa/dhr/benefits**.
- Evidence of Insurability (EOIs) MUST be completed when an employee or spouse is applying for new coverage or increasing coverage during open enrollment. New this year, the EOI process will take place within the online Benefits Administration System (BAS). At the conclusion of your open enrollment choices, you will be offered a button to begin the EOI process. You complete the EOI form and submit it immediately and electronically to Minnesota Life. This process will result in faster turnaround times for the review of the EOI.
- Open Enrollment is an excellent time to confirm or change life insurance beneficiaries.
- New this year—Within the online BAS, the children with optional child life coverage must be listed—name, age, social security number—and the voluntary child life insurance must be indicated for the child by clicking the "yes" button next to their names on the screen for optional child life insurance. Nothing is changing with optional child life coverage and employees still will pay only one premium for all eligible dependent children.
- Find more information about Optional Life Insurance at **www.colorado.gov/dpa/dhr/benefits**, click on "Life Insurance."

Long-Term Disability (LTD) Insurance—Provided by Standard Insurance

- There are no changes to the voluntary long-term disability (LTD) plan or premiums. See the **Benefits Web site** for premiums.
- LTD premiums are a factor of your monthly salary, your age, and your vesting status with PERA.
- Medical History Statements MUST be completed when LTD is elected. This form is available on the Employee Benefits Web site—**www.colorado.gov/dpa/dhr/benefits**, click on "Disability Plans." After completing your open enrollment, download the form, complete it and send to Standard Insurance Company at the Portland, Oregon address at the top of the form.
- Find more information about the LTD program at **www.colorado.gov/dpa/dhr/benefits**, click on "Disability Plans."

Flexible Spending Accounts (FSAs)—Administered by ASI Flex

www.asiflex.com/1.800.659.3035

- Flexible Spending Accounts (FSAs) do not roll over to the next plan year, so ***those who want an FSA in the next plan year (FY11, July 1, 2010–June 30, 2011) MUST enroll in the FSA during open enrollment***.
- Two types of FSAs: Healthcare FSA and Dependent Care FSA
- Remember, a Dependent Care FSA ***does not*** cover *medical* expenses for dependents. It can ONLY be used for reimbursement of eligible child care (children under 13) and elder care expenses that allow you and your spouse to work.
- Healthcare FSA—Maximum *ANNUAL* contribution: $6,000
- Dependent Care FSA—Maximum *ANNUAL* contribution: $5,000
- Please review your contributions (annual contributions and how those translate into monthly amount) as the federal tax code does not allow changes or corrections once the plan year begins on July 1.
- ***Please be advised:*** *As part of federal health reform, over-the-counter (OTC) medications will no longer be qualifying medical expenses, unless obtained with a prescription. Other reforms will not impact the State's FSA at least until the plan year after next (FY12, July 1, 2011–June 30, 2012).*

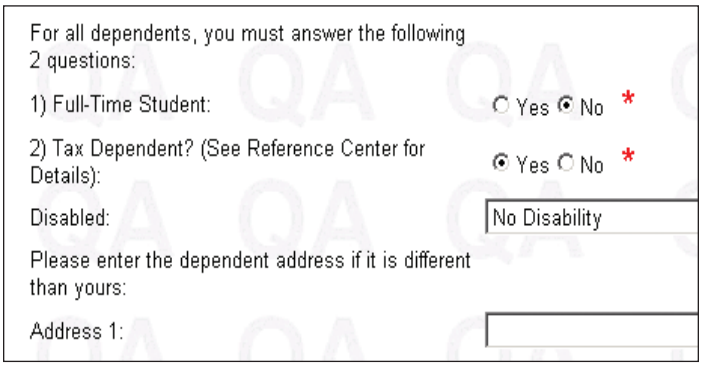
Dependents? Tax or Non-tax?

Either way, you gotta let us know

As part of this open enrollment, *everyone* has to indicate the tax status of their dependents listed in the online Benefits Administration System (BAS).

What does that mean? It means that you have to tell us if your dependents (spouse, children, same-gender domestic partner [SGDP] or your SGDP's children) are or are not considered tax dependents by the IRS.

Screenshot showing tax dependent question in the BAS



How do you determine the tax status?

On the State's benefits Web site, you can find resources to help you address the question of your dependents' tax status.

- Tax Dependent Questions & Answers
- Dependent Tax Status Definitions
- IRS Publication 501 and link to **www.irs.gov**
- Instructions on reviewing/updating tax status in the BAS

In most cases, a married employee with minor children should be able to determine the tax status by reviewing these resources. Employees who have children but are divorced, or who have children age 19 or older, or who have disabled adult children, or employees with an SGDP or the SGDPs children, may need to dig deeper into these resources, and may need to seek the advice of a tax professional to determine the tax status of their dependents.

However, employees should understand that no one in your human resources (HR) or benefits office can tell you, or even advise you, of the tax status of your dependents. HR and benefits personnel are not tax professionals and may only point you in the direction of resources to determine the status.

Why is this required?

The money your employer, the State, pays for your benefits is part of your compensation—what the State gives to you in exchange for your work. However, unlike your pay, the IRS does not tax the money paid for your benefits *IF* the dependents you cover are tax dependents. If you cover non-tax dependents, the IRS says the money the State contributes to your benefits becomes taxable.

What happens if you cover a non-tax dependent?

Simply put, a little more in taxes will come out of your paycheck. Sure, that doesn't sound good, but remember that even though you are paying more in taxes, your dependents will have medical and/or dental insurance.

The tax is determined by the amount of "imputed income"—a dollar amount representing the value contributed by the employer—added to your taxable pay. This dollar amount is not given to you as pay, but is added to the amount that is considered taxable income. Your taxes are then calculated on this higher amount. Note that the same amount is added to your taxable income regardless of the number of non-tax dependents you are covering.

See the table for additional taxable income at **www.colorado.gov/dpa/dhr/benefits**.

What happens if you mark your non-tax dependent as a tax dependent?

If you list your non-tax dependent incorrectly, then your taxes will be calculated incorrectly. If you do not have enough money taken out for taxes, or if you file your taxes without reflecting this, you risk having to pay more later, including interest and penalties imposed by the IRS.

Can you change the tax status of your dependents?

Yes, at anytime you can change the tax status of your dependents. If, as you research this question further, you realize you've made a mistake, you can change the designation. If your dependent's situation changes, for example, your child graduates from college, you can and should change the dependent's tax status.

Remember—during this open enrollment, your MUST indicate if your dependents are tax or non-tax dependents.

Updating Your Mailing Address

During this time of year, open enrollment, it is extremely important for you to update your mailing address.

Your *mailing* address? In this age of e-mail, Facebook, and Twitter? Updating a snail-mail address?

Yes. Why? After open enrollment, the medical and dental ID cards for you and your family will be ***MAILED*** to you. If you do not update your mailing address now, you will not get these cards. This means, should you need to go to the doctor or dentist in July (a Fourth of July accident perhaps?), not having the ID card will make it more difficult than it needs to be.

How to update your mailing address

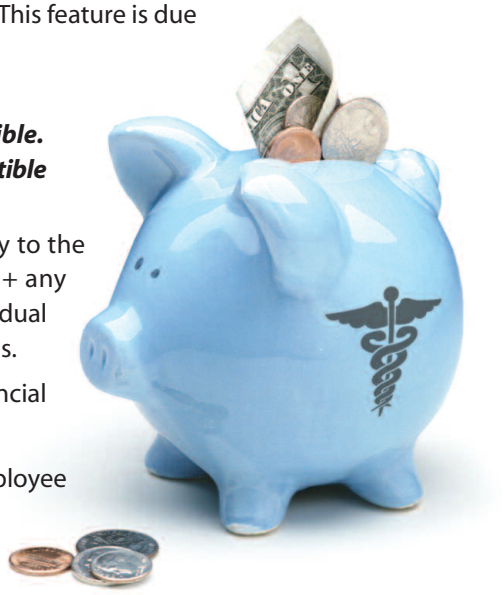
- Contact your agency's *payroll office* so that your address changes can be entered into the payroll system. These changes are then fed to the online Benefits Administration System (BAS).
- **For employees in higher education (two and four-year schools)**—Contact your payroll AND benefits office to make sure the changes are made in all systems.
- Don't know your agency's payroll or benefits personnel? Review **this list** to find the right people.

Health Savings Accounts (HSAs)

A Health Savings Account (HSA) is a special kind of savings account, similar to an IRA, to save for future medical expenses. You cannot establish or contribute to an HSA without being enrolled in an HSA-qualified plan (also called a high deductible health plan or HDHP). In FY11, there will be two HSA-qualified plans available for state employees, the Choice Plus Definity option of the self-funded plan, and the Kaiser HSA-qualified option (although Kaiser options are only available to employees in certain geographic areas). These options are designed primarily for those who have or plan to open an HSA, although an HSA is not required to enroll in these plans. These options are also designed to meet the federal regulations for being HSA-qualified.

Important Factors When Considering an HSA-qualified option

- All covered services, except for certain preventive services, are subject to the medical deductible.
- Prescriptions and HSA-qualified options
  - Unlike the other medical insurance options, **within an HSA-qualified option, the entire deductible amount must be met before the prescription co-payment amounts apply.** This feature is due to federal regulations for HSA-qualified plans.
- Individual vs. Family Deductibles
  - ***Unlike the other options, an HSA-qualified option has an "umbrella" deductible. This means that if you have family coverage, you must pay the full family deductible before benefits are payable.***
  - The individual deductible and maximum out-of-pocket amounts ONLY apply to the Employee-Only tier of coverage. For all other levels of coverage (employee + any dependents—spouse, SGDP, and/or any number of children) there are no individual amounts, only the family amounts of deductibles and out-of-pocket maximums.
- Those who want an HSA should know that they can set up an account at any financial institution they choose.



To review more information about the HSA-qualified medical options, visit the Employee Benefits Web site, **www.colorado.gov/dpa/dhr/benefits**.

Do you have **Optional Child Life Insurance?**

Then read this.

Employees with optional child life insurance for their children (formerly called dependent life insurance) will have a new step in the upcoming FY11 Open Enrollment May 4–May 20, 2010).

Within the online Benefits Administration System (BAS), the children with optional child life coverage must be listed—name, age, social security number—and it must be indicated that the life insurance is for them by clicking the "yes" button next to their names on the screen for voluntary child life insurance.

Nothing about the coverage is changing. One monthly premium will cover all eligible children in an employee's family. The employee is still the beneficiary for the optional child life insurance. The eligibility requirements for dependent children are not changing (see "Eligibility Requirements" to the right).

Why do this? Up until now, employees have not had to list their children for dependent life coverage, which means that there is nothing to track when children reach maximum age and lose eligibility for optional child life insurance.

Not tracking the dependents or their ages has two consequences. First, in the case of an only child or the youngest child, an employee is paying premiums needlessly for coverage for which the child is not eligible. The second, and more serious consequence, is when an unfortunate event occurs and a child dies. If the child had reached maximum age and was ineligible, it will not be discovered until the claim for the child's life insurance is made, and the claim is denied. This is an unpleasant and heartbreaking situation for everyone. Yet these situations can be avoided by requiring that dependents covered by optional child life insurance be listed individually in the BAS.

If you have questions about how to list your dependents in the BAS, please contact your agency's human resources or benefits office.

Eligibility Requirements for Optional Child Life Insurance

Each employee's unmarried child, including adopted children, stepchildren and foster children, through the end of the calendar year in which the child turns 19, for whom the employee is the major source of financial support or for whom the employee is directed by court order to provide coverage.

Each unmarried child 19 through the end of the calendar year in which that child is no longer a full-time student in an educational or vocational institution, but no longer than through the end of the month in which the full-time student turns 24 years of age, and for whom the employee is the major source of financial support or for whom the employee is directed by court order to provide coverage.

An unmarried child of any age who has either a physical or mental disability, as defined by the carrier, not covered under other government programs, and for whom the employee is the major source of financial support or for whom the employee is directed by court order to provide coverage.

Division of Human Resources

Same-Gender Domestic Partners:
How to enroll during open enrollment

Employees with same-gender domestic partners (SGDPs) can now add their partners to their medical and dental coverage during this year's open enrollment, with coverage effective beginning July 1, 2010.

Affidavit Required

Employees adding an SGDP to their coverage must complete, have notarized, and submit a "Same-Gender Domestic Partner" affidavit. This affidavit will be available on the Employee Benefits Web site—**www.colorado.gov/dpa/dhr/benefits**. Employees must provide this completed affidavit to their agency's human resources or benefits office by June 30 to have coverage in place for July 1.

Enrolling on the Online BAS

Within the online Benefits Administration System (BAS), the process will be simple. On the dependent screen, the employee adds the SGDP as a dependent by clicking "add dependent."

On the next screen, the employee must choose "SGDP" as the relationship and then fill in all of the required information.

The employee MUST designate the tax status (tax or non-tax dependent) of the SGDP, as well as the tax status of any children listed. Social security numbers are also required.

On the medical and dental screens, the SGDP level of coverage is now included with the same levels as the spouse. Thus, there will be "Employee + Spouse/SGDP," and the "Employee + Family" level is inclusive of a SGDP. The employee selects the level of coverage desired.

Optional Life Insurance for SGDPs Not Yet Available

Optional life insurance for SGDPs will NOT be part of this year's open enrollment process, but it will be available for the beginning of the FY11 plan year (July 1, 2010). At that time, SGDPs will be eligible for voluntary life insurance in a similar way that spouses are eligible, which means no more than half of the amount approved for the employee.

Employee Benefits is making improvements to the plan and to the online BAS to accommodate SGDPs and these changes will not be in place until July. We will provide more information as July 1 draws near.

SGDPs, Spouses and Common Law

With the inclusion of same-gender domestic partners, the following partners for employees will now be eligible for the State's medical, dental and optional life coverage.

- Legally married spouse (spouse is opposite gender)
- Common-law spouse (spouse is opposite gender)
- Same-gender domestic partner

Opposite-gender domestic partners ARE NOT eligible for coverage under the state plans. Opposite-gender domestic partners are distinct from common-law spouses.

Can You Cover Your Grandchild?

Starting in the FY11 plan year, July 1, 2010–June 30, 2011, employees wishing to cover their grandchildren as their dependents for medical and dental coverage with the State will have to provide documentation. This applies even to a grandchild born to an employee's minor child. Only two types of documentation will be accepted to allow the coverage of grandchildren.

- **An Allocation of Parental Responsibility/legal custody**—The employee has an official court document granting allocation of parental responsibility (legal custody) that specifies responsibility for health insurance.
- **Adoption documents**—Official adoption papers showing the grandparent has or is adopting the grandchild as his or her own child.
- **If an employee has previously provided documentation for legal custody or an Allocation of Parental Responsibility, the employee should verify that a copy is on file with his or her agency's human resources/benefits office.**

Employees unable to provide such documentation for their grandchildren *WILL NOT* be able to continue coverage, and their grandchildren's medical and dental coverage will be cancelled June 30, 2010.

Will these documents be required for open enrollment?

Yes, as grandchildren without the documentation will have their coverage cancelled **June 30, 2010**, before the beginning of the new plan year.

Employees will not need the documents to complete their open enrollment in the online Benefits Administration System (BAS), but employees MUST provide these documents to their human resources/benefits office during open enrollment, and no later than June 30, 2010, so that coverage for a grandchild will be able to start or continue on July 1, 2010.

If you do not have such documentation, please contact a lawyer or your county about how to begin this process.

Questions or Problems?

- **Technical questions** about the online system, such as warnings from your computer or difficulties connecting to the site? Call **1.888.460.9627**
- **Questions about the medical and dental plans** (covered procedures, prescriptions, doctors, etc.)? Contact the carriers or plan administrator directly.
  - United Healthcare—1.877.283.5424/**www.welcometouhc.com/colorado** (a pre-member information site)
  - Kaiser Permanente—303.338.3800/1.800.632.9700/**kaiserpermanente.org**
  - Delta Dental—1.800.489.7168/**deltadental.com**
- **Problems with username/password in the Benefits Administration System (BAS)**—Try going through the password recovery process by clicking on "Forgot your password" on the BAS login page. If that doesn't work, call the technical help line at **1.888.460.9627**. If you still have problems, contact your human resources or benefits office. Go to the **Benefits Web site** and click on **"Your department's HR/benefits personnel"** for a complete departmental list.
- **Questions about eligibility or Internet access?** Contact your human resources or benefits office. Go to the **Benefits Web site** and click on **"Your department's HR/benefits personnel"** for a complete departmental list.

Medical Insurance Supplement Program in FY11?

Current recipients of the Medical Insurance Supplement should not assume that the program will continue into the next plan year, FY11, and if it does continue, should not assume that they will receive the supplement or that the supplement will cover 100% of their medical premium.

These current recipients should also understand that their FY10 supplement will end after June 2010. Whether the Supplement Program continues or not, these employees should be careful when making decisions during open enrollment.

As is the case every year, the future of the Medical Insurance Supplement Program in the coming FY11 plan year is uncertain, as the money for the program must be approved by the legislature. ***IF the program does continue in FY11***, Employee Benefits will provide more information in June and July. Everyone interested in the supplement must apply and provide documentation during the application period. This includes current FY10 supplement recipients, who will need to complete a new application and provide updated documents. The program will only be available to employees with dependent children, and income eligibility will be based on **2009** Federal Poverty Levels, or FPL. Those with household incomes above 300% of the FPL are ineligible.